**STATE OF MICHIGAN**

**DEPARTMENT OF LABOR & ECONOMIC GROWTH**

**OFFICE OF FINANCIAL AND INSURANCE REGULATION**

**Before the Commissioner of Financial and Insurance Regulation**

**In the matter of**

**XXXXX**
**Petitioner** **File No. 100502-001**

**v**

**Physicians Health Plan of Mid-Michigan**
**Respondent**
_____/

**Issued and entered**
**this 28th day of October 2008**
**by Ken Ross**
**Commissioner**

**ORDER**

## I
## PROCEDURAL BACKGROUND

On September 30, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.* On October 7, 2008, the Commissioner accepted the request.

The issue in this external review can be decided by a contractual analysis. The contract is the certificate of coverage (the certificate) issued by Physicians Health Plan of Mid-Michigan (PHPMM). The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

## II
## FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in the certificate. The certificate provides for both network and non-network benefits. To obtain network benefits, the care must be provided

by a network provider. Care from non-network providers may be covered but it generally comes with a higher out-of-pocket cost for the PHPMM member. The certificate permits network-level benefits for out-of-network services when the services are not available from network providers or in an emergency.

The Petitioner was diagnosed with a patent foramen ovale (PFO). A PFO is a defect in the septum (wall) between the two upper chambers of the heart. The defect is an incomplete closure of the atrial septum that results in the creation of a flap or a valve-like opening in the atrial septal wall. It is seen frequently in everyone before birth but seals shut in about 80 percent of people.

PFO closure surgery was performed at the XXXXX Hospital (WBH) by XXXXX, on June 2, 2008. XXXXX and its doctors are not part of PHPMM's network and PHPMM denied the Petitioner's request that their services be covered at the network level.

The Petitioner appealed the denial and after exhausting its internal grievance process received PHPMM's final adverse determination dated August 4, 2008.

## III
## ISSUE

Did PHPMM properly deny coverage for the Petitioner's surgery at the network level?

## IV
## ANALYSIS

Petitioner's Argument

The Petitioner has a history of chronic migraines for many years; and a history of stroke in 1991. Nothing she has tried in an attempt to control her headaches seemed to help.

A transesophageal echocardiogram (TEE) was performed on March 24, 2008. After he saw her on March 28, 2008, the Petitioner's cardiologist, XXXXX, MD, wrote:

> The recently performed TEE suggests a small PFO with left to right shunt only by contrast bubble study. The cause of relations of this finding to her previous neurologic event and possibly the chronic migraine headaches is not entirely clear. As per the [Petitioner's] wishes, she will be referred to Dr. XXXXX at XXXXX to discuss further especially with regard to possible percutaneous closure of this PFO.

XXXXX, MD, a cardiologist at XXXXX, said in a letter dated May 23, 2008:

> The response of migraine headaches to PFO closure is variable. However, given the persistent disabling nature of her migraine headache, and history of cryptogenic CVA, PFP closure would be a reasonable option. She was informed that PFO closure would reduce her risk of future embolic stroke and may or may not have any impact on the frequency or severity of her migraine headaches.

The Petitioner argues that she should be allowed network coverage for the services provided by Dr. XXXXX and XXXXX. The Petitioner says that although PHPMM sent her a list of doctors who perform PFO's, her physicians recommended Dr. XXXXX as the best qualified. She notes that Dr. XXXXX and Dr. XXXXX believe Dr. XXXXX is the only physician in the state of Michigan who is capable of performing the procedure. In a letter to PHP dated September 11, 2008, Dr. XXXXX wrote in support of the Petitioner's request to have the PFO closure treated as an in-network benefit:

> This is a 32-year-old woman who has been suffering from essentially daily migraine headache, and she also has a history of transient cerebral ischemic event during her late teens. She was recently diagnosed with patent foramen ovale for which she was referred for consideration of percutaneous closure with Dr. XXXXX at XXXXX. As you may be aware, there are only a few very competent cardiologists who carry out the procedure, and Dr. XXXXX with his expertise was thought to be the proper physician for this procedure.

Additionally, the Petitioner believes it was an error by Dr. XXXXX's office that she was not informed Dr. XXXXX was not in PHPMM's network causing her to be responsible for paying for an out-of-network provider.

The Petitioner believes PHPMM should cover the PFO closure at the network level because Dr. XXXXX had special expertise and the surgery is not available within the PHPMM network.

Physicians Health Plan's Argument

In its August 4, 2008, final adverse determination, PHPMM said:

> [The] grievance committee reviewed your grievance for in-network coverage of services received at XXXXX Hospital with non-network provider Dr. XXXXX on 6/2/08 and 6/3/08. The original decision to deny your request was upheld because the services are available within the [PHPMM] network.

PHPMM cites these provisions in the certificate to support its decision:

**Section 1: What's Covered – Benefits**

**Accessing Benefits**
You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits, Covered Health Services must be provided by a Network Physician or other Network provider in the Physician's office or at a Network facility. For facility services, Network Benefits apply to Covered Health Services that are provided at a Network facility by or under the direction of either a Network or non-Network Physician or other provider. For details about when Network Benefits apply see Section 3: Description of Network and Non-Network Benefits.

* * *

**Section 3: Description of Network and Non-Network Benefits**

**Network Benefits**
Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services which are:

- Provided by or under the direction of a Network Physician in a Network Physician's office or at a Network facility.
- Emergency Health Services.
- Urgent Care Center services.

* * *

***Health Services from Non-Network Providers Paid as Network Benefits***
If we determine that specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us, and we will work with you and your Network Physician to coordinate care through a non-Network provider. You are responsible for verifying that we have approved the request. If you see a non-Network provider without verifying in advance that we have approved your visit, Network Benefits will not be paid. Non-Network Benefits may be available if the services you receive are Covered Health Services for which Benefits are provided under the Policy.

**Non-Network Benefits**
Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services which are any of the following:

- Provided by a non-Network Physician or other non-Network provider.
- Provided at a non-Network facility.

According to PHPMM, a request to consider in-network coverage for Dr. XXXXX's surgery was received in late May 2008. Before PHPMM finished reviewing the request, the Petitioner had the surgery at XXXXX on June 2, 2008.

In a letter dated June 12, 2008, PHPMM denied the Petitioner's request for network level benefits and gave the Petitioner the name of XXXXX, a provider in its network that provides cardiac surgical procedures. The letter also directed the Petitioner to the provider directory and suggested she contact customer service for assistance in finding other cardiology providers. PHPMM also advised the Petitioner that she could use her non-network benefits for care with Dr. XXXXX at XXXXX but said that would require satisfying a deductible and then paying 20% coinsurance.

Based on the language in the certificate, PHPMM believes that it appropriately denied coverage at the network level.

Commissioner's Review

The certificate has two levels of benefits and the Petitioner can receive medically necessary and covered services from either network or non-network providers. Services from a non-network provider may be covered at the network level under certain circumstances, e.g., services for urgent or emergency care, or when PHPMM does not have the needed care available within its network.

It is the Petitioner's contention that the particular procedure she needed (closure of the PFO) was not available within PHPMM's network – she believed that the PFO procedure would be best performed by Dr. XXXXX. However, PHPMM identified a provider in its June 12, 2008, letter (the XXXXX cardiology center) and said additional names were available in its provider directory or from a customer service representative.

The Petitioner also argued that Dr. XXXXX has greater expertise to perform the PFO closure procedure than any of PHPMM's network providers. Even PHPMM, on its website, recognizes that experience in performing certain procedures can be a factor in selecting a physician. However, even if it is true that Dr. XXXXX has had more experience with the procedure the Petitioner seeks,

the Commissioner has no basis for concluding that experience alone would require PHPMM to cover the Petitioner's care with him when it has qualified providers in its network.

The record here does not establish that PHPMM's network cardiac surgeons are not able to provide the Petitioner's medically necessary services, or that the Petitioner followed the certificate's requirements for getting prior authorization to use a non-network provider at the network benefit level. The Commissioner therefore finds that PHPMM's determination of benefits was appropriate -- it is not required to cover any services from Dr. XXXXX and XXXXX at the network level.

## V
## ORDER

The Commissioner upholds PHPMM's final adverse determination of August 4, 2008. PHPMM is not required to provide network level coverage for the Petitioner's requested services from non-network providers (Dr. XXXXX and XXXXX).

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.